Tulalip Tribes of Washington

Employee Health Care Enrollment Form

Group Number: 4137

For HMA Use Only
In System _____
To PCS _____
Elig. Rep. Initials _____

☐ New Enrollee ☐ Coverage Change ☐ Name Change ☐ Address Change ☐ Open Enrollment ☐ Tulalip Native American ☐ Native American Non-Tulalip

Drop Spouse/Dependent **Reason**: _____ ☐ Add Spouse/Dependent **Reason**: _____

If Adding Spouse, Date of Marriage: _____ Status Change: ☐ Temporary to Permanent ☐ Leave of Absence - Date returned from LOA: _____

(If adding dependent(s) due to adoption, court order, or legal guardianship, you must provide legal documentation.)

☐ Transfer to COBRA ☐ Termination Date: _____ Qualifying Event: _____ ☐ Rehire Date: _____

☐ **Waiver of Coverage**

Soc. Sec. # _____ **Date of Birth** ____/____/____ **Gender**: ☐ M ☐ F **Telephone Number** (_____) _____

Participant Last Name _____ **First Name** _____ **M.I.** _____

Mailing Address _____ **City** _____ **State** _____ **Zip Code** _____

Life Insurance: May list one or more beneficiaries. List additional beneficiaries on a separate sheet of paper and attach it to this enrollment form. If listing one beneficiary, that individual will receive 100% of the benefit. Please indicate percentage of benefit for multiple beneficiaries. Total percentages must equal 100%.

Beneficiary: _____ **Relationship:** _____ **Percentage:** _____

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ELECT ONE PLAN ONLY	**BASE PLAN = No Deductible** Office Visit: $15 copay **Medical/Vision/Rx/Life**	**Dental**	**BUY-UP PLAN = No Deductible** Office Visit: $15 copay **Medical/Vision/Rx/Life**	**Dental**	**Life ONLY**
	Myself: ☐	Myself: ☐	Myself: ☐	Myself: ☐	Yes: ☐
	Spouse: ☐	Spouse: ☐	Spouse: ☐	Spouse: ☐	
	Child(ren): ☐	Child(ren): ☐	Child(ren): ☐	Child(ren): ☐	

COMPLETE SECTION BELOW ONLY IF ENROLLING DEPENDENTS (sex, date of birth, and social security number required):

First Name	M.I.	Last Name	Sex	Date of Birth	D=Daughter S=Son	Social Security #	Native Americans – Enrolled Tulalip	Native Americans – Enrolled Non-Tulalip	Other
					Spouse		Yes: ☐	Yes: ☐	Yes: ☐
							Yes: ☐	Yes: ☐	Yes: ☐
							Yes: ☐	Yes: ☐	Yes: ☐
							Yes: ☐	Yes: ☐	Yes: ☐
							Yes: ☐	Yes: ☐	Yes: ☐
							Yes: ☐	Yes: ☐	Yes: ☐

If dropping spouse/dependents please list name(s):

Name: _____ Term date: _____ Reason: _____

Name: _____ Term date: _____ Reason: _____

Student Eligibility / Disabled Child

Is any dependent child listed above, over age 19 and a full-time student at an accredited school? ☐ Yes ☐ No

Dependent: _____ School _____ Current Qtr & Yr Attending _____

Dependent: _____ School _____ Current Qtr & Yr Attending _____

List child who is developmentally disabled or physically handicapped who is over age 18:

Name: _____ **Medical documentation must be submitted within 31 days of the effective date of coverage**.

Prior Insurance Coverage Information

Have you had coverage prior to enrollment on this plan? ☐ Yes ☐ No ***If yes, attach a copy of any Certificates of Creditable Coverage.***

Type of coverage: ☐ Medical ☐ Dental ☐ Vision ☐ Other _____

List yourself and family member(s) who are listed above and were covered on your previous insurance plan. If effective or termination date for any family member is different than the employee's, attach a Certificate of Creditable Coverage for that individual.

Coordination of Benefits Information

If yes, please complete the following:

MARITAL STATUS: ☐ SINGLE ☐ MARRIED_____ ☐ WIDOWED ☐ LEGALLY SEPARATED ☐ DIVORCED
NAME OF SPOUSE

IF DIVORCED, IS THERE A COURT ORDER FOR PROVISION OF THE CHILD? ☐ YES ☐ NO IF YES, ATTACH A COPY OF THE COURT DECREE. PER THE COURT DECREE:

WHO HAS CUSTODY OF CHILD? _____ WHO NEEDS TO PROVIDE INSURANCE FOR CHILD? _____

LIST THE FULL NAME OF CHILD(REN) _____

LIST BOTH NATURAL PARENTS: NATURAL FATHER _____/ BIRTH DATE _____ NATURAL MOTHER _____/ BIRTH DATE _____

List all family member(s), including yourself, who are included on this enrollment form and are currently covered through another plan.

Name of covered members:	Type of Coverage: (M)edical (D)ental (V)ision	Type of Policy: (G)roup (I)ndividual	Effective date of coverage:	Carrier Name:
_____	_____	_____	___/___/___	_____
_____	_____	_____	___/___/___	_____
_____	_____	_____	___/___/___	_____

Provide the following information on the carriers listed above:

Carrier Name: _____ Policy Number: _____ Carrier phone #: _____

Street Address: _____ City: _____ State _____ Zip _____

Subscriber's Name: _____ Social Security Number: _____ Date of birth:_____

Employer's Name and Address (if group coverage) _____

IS EMPLOYEE, SPOUSE/DOMESTIC PARTNER COVERED UNDER THIS MEDICAL PLAN ELIGIBLE FOR MEDICARE BENEFITS ☐ YES ☐ NO

IF YES, ENTER DATE OF ELIGIBILITY FOR MEDICARE PART A _____OR FOR MEDICARE PART B_____SOCIAL SECURITY NO._____

I certify that the above listed information is correct and that I am enrolling only eligible dependents as defined in the Plan Document. I understand that all entitlements to benefits are void, and coverage may be canceled or modified retroactively to its effective date, if I have made intentionally false or misleading statements or answers on behalf of myself or any family members. I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information to release any and all information pertaining to the care or benefits provided to me or my dependents to Healthcare Management Administrators or its designated agent.

I acknowledge and understand that my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. *

Health information requested or disclosed may be related to treatment or services performed by: 1) A physician, dentist, pharmacist or other physical or behavioral health care practitioner; 2) A clinic, hospital, long term care or other medical facility; 3) Any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or 4) An insurance carrier or group health plan. Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.
* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Privacy Notice. A copy is available upon request.

Employee's Signature_____ **Date Signed** _____

EMPLOYER SECTION

Location: ☐ Administration_____ ☐ Utilities ☐ Casino/Bingo ☐ Tribal Gaming Agency ☐ Quil Ceda Village ☐ Housing Special Enrollment: ☐ Yes ☐ No (If yes, attach waiver of health coverage)

Date Hired: _____ Coverage Effective Date:_____ Effective Date of Change: _____ Certified by: _____ Today's Date: _____